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Report to the Ranking Minority Member, Committee on Veterans' Affairs, U.S. Senate

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VA HEALTH CARE

Improvements Needed in Procedures to Assure Physicians Are Qualified

GAO/HRD-89-77

GAO

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Human Resources Division

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The Honorable Frank H. Murkowski
Ranking Minority Member
Committee on Veterans' Affairs
United States Senate

Dear Senator Murkowski:

In response to your request, this report discusses the effectiveness of credentialing and privileging efforts at selected medical centers within the Department of Veterans Affairs (VA). In this report we identify several areas in which medical centers either are not adhering to existing guidance (e.g., credentialing) or are receiving insufficient guidance to perform effectively (e.g., privileging). We also discuss how some problem physicians are allowed to leave VA with no indication on their record of prior difficulties involving their competency.

Several recommendations are made to improve these conditions, all but one of which VA either concurs with or agrees to in principle. The one area in which VA differs with us involves the criteria for reporting problem physicians to licensing boards. We have recommended a legislative change to resolve the problem, but VA is proposing to address it through regulation. In addition, VA is proposing reporting criteria that we believe are too limited.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 10 days from its issue date. At that time, we will send copies to the Secretary of Veterans Affairs, appropriate congressional committees, and other interested parties.

The report was prepared under the direction of David P. Baine, Director, Federal Health Care Delivery Issues. Other major contributors are listed in appendix III.

Sincerely yours,

Lawrence H. Thompson

Lawrence H. Thompson
Assistant Comptroller General

Executive Summary

Purpose

Public Law 99-166, enacted in 1985, required the Department of Veterans Affairs (VA) (formerly the Veterans Administration) to report to the Senate and House Veterans' Affairs Committees on the actions it planned to take to improve its physician credentialing process. In March 1986, VA advised the Committees that it would be revising its guidance concerning both its credentialing and privileging processes and stated that it would inform state licensing boards and the Federation of State Medical Boards of VA physicians found to be clinically incompetent. The Ranking Minority Member of the Senate Committee on Veterans' Affairs asked GAO to evaluate VA's compliance with the revised credentialing process and to review how VA grants and removes physician privileges.

Background

Verifying physicians' credentials (credentialing) and examining their ability to perform specified procedures (privileging) are important elements of an effective quality assurance program. Credentialing involves the complete, systematic review of the licenses, education, and training of all applicants seeking appointment in a medical facility. Privileging involves evaluating physicians' clinical experience, competence, ability, judgment, and health status when granting them permission to treat certain illnesses and perform certain medical procedures.

In 1985, VA's Inspector General reported that (1) VA medical centers were not identifying sanctions against physicians' credentials (e.g., licenses) and (2) VA had no system or mechanism to assure that all its physicians were appropriately privileged. Problems with VA's privileging process were also found during separate reviews by the Joint Commission on Accreditation of Healthcare Organizations and VA regional office survey teams.

Results in Brief

Credentialing and/or privileging problems identified before the enactment of Public Law 99-166 were still in evidence at the eight medical centers GAO reviewed in 1987-88. State licenses were not being consistently verified with state boards; residents' backgrounds were not being adequately checked; privileges were not reviewed in a timely manner; credentialing and privileging decisions were not documented; physicians found to be deficient did not have their privileges formally reduced; and the names of physicians found to be incompetent were either not submitted to state licensing boards and/or the federation or not submitted in a timely manner.

Principal Findings

VA's Compliance With Credentialing Procedures Needs Improvements

VA medical centers are required to obtain licensing information from the state boards on physician applicants to determine whether they had any disciplinary action(s) taken against them. GAO's review of 207 case files of physicians who had been hired by VA between 1986 and 1988 showed that only 102 verifications were made and properly documented. (See pp. 16-19.) This situation is occurring because medical center personnel are not following credentialing guidance and regional offices are not effectively monitoring centers' compliance with VA procedures.

In 34 of the 105 undocumented cases, medical center officials informed us that they had contacted a cognizant state board. But failure to document is contrary to established VA guidance and is in violation of internal control standards. By not following procedures, VA medical centers could unknowingly hire "problem" physicians and/or be allowing physicians with sanctions against their licenses to treat veterans.

Expanded Credentialing Requirements Could Identify More Problem Resident Physicians

Organizations familiar with credentialing procedures in both federal and nonfederal hospitals informed GAO that VA's procedures are adequate if they are followed but could be improved. (See pp. 21-24.) One of their suggestions was to require medical schools that have affiliation agreements with VA to assure that background checks are made on residents they send to VA to serve a part of their residency programs. The suggestion has significant merit. In comparing the names of resident physicians on VA rolls as of June 1985 with Federal Bureau of Investigation records, GAO found that 165 of the 16,756 residents had been charged with 275 criminal offenses from the early 1970s to May 1987. (See p. 22.) In May 1988, these results were discussed with VA's Chief Medical Director, who indicated that VA was planning to require affiliated medical schools to conduct the background examinations. As of May 1989, the guidance needed to implement this action had not been issued.

Privileging Procedures Must Be Developed and Adhered to

Problems in VA's privileging processes have been identified several times since 1980. In each instance, VA stated that corrective action would be taken. (See pp. 27-29.) But the problems still existed in 1988. In a sample of 239 case files, GAO found 62 physicians whose privileges had not been approved or renewed. Of the 177 privileging decisions that had been made, none had documentation to show whether current competence, results of treatment, or conclusions drawn from quality assurance

information had been considered. (See pp. 30-32.) GAO also found (1) one medical center that had not granted privileges to any of its 264 consulting and attending physicians and (2) three situations at two centers where physicians' performance was questioned and their privileges were informally rather than formally reduced. (See pp. 32-35.)

The conditions cited do not mean that the medical services provided by VA are substandard or that VA physicians are incompetent. It does mean, however, that VA cannot assure the public or the veterans it serves that its physicians are appropriately privileged.

These situations exist because VA provides minimal guidance to the medical centers on who should be privileged and no guidance on what documentation is required to support a privileging decision. Further, medical center officials are reluctant to formally reduce or revoke physicians' privileges for fear of litigation against VA or specific individuals.

Reporting of Sanctioned Physicians to Licensing Boards Needs Improvement

VA policy requires that state licensing boards be notified of physicians who have their privileges formally revoked for clinical incompetence or who resign or retire after a reduction in privileges or while under investigation for clinical incompetence. Further, those physicians would also be reported to the federation.

There are two major limitations on reporting. First, Public Law 99-166 limits VA to reporting physicians to state licensing boards and the federation only for clinical incompetence, not for fraud or other such actions that do not necessarily affect clinical competence. (See p. 40.) Second, VA is reluctant to send to the federation the names of physicians who resign or retire before receiving a hearing because an opportunity for such a hearing is a due process right. As a result, some problem physicians are allowed to leave VA with no indication on their records of prior problems. (See pp. 42-43.) From January 1986 through September 1988, medical centers requested VA medical inspector and general counsel approval to submit the names of 37 physicians to a state board. Approval was granted to send 12 names to the states. But, because of due process considerations, only 6 of these names were sent to the federation. VA rejected 17 requests because either the medical center did not submit adequate supporting documentation or the physician left VA for reasons other than clinical incompetence. Of the remaining cases, five were pending as of May 1989, and three were closed because either a medical school or the U.S. attorney took action against the physician.

Recommendations to the Agency

GAO recommends that the Secretary of Veterans Affairs require the Chief Medical Director to (1) issue comprehensive privileging guidance (see p. 36); (2) develop procedures to assure that regional offices effectively monitor medical centers' compliance with VA's credentialing and privileging guidance (see pp. 25 and 36); (3) obtain assurances from medical schools that all residents sent to VA have had their background examined (see p. 25); and (4) work with the Office of General Counsel to develop a policy and issue guidance on procedures to provide due process for physicians who resign or retire while being investigated for incompetence (see p. 47).

Recommendation to the Congress

The Congress should amend Public Law 99-166 to expand the physician reporting criteria beyond clinical incompetence (see p. 47).

Agency Comments

VA concurred with or agreed in principle to each of GAO's recommendations for agency action. VA stated that steps are already being taken to live up to the letter and spirit of Public Law 99-166 and correct the credentialing and privileging problems identified by GAO.

VA presented an alternative to GAO's recommendation to the Congress that Public Law 99-166 be amended to expand physician reporting criteria beyond clinical incompetence. VA proposes to develop immediately, new and comprehensive regulations that will clearly require medical center reporting of problem physicians and other health care professionals. The reporting criteria will, however, exclude nonclinically related offenses, such as a conviction for income tax problems. According to VA if, during the development of these regulations, it finds that statutory authority is necessary, a legislative proposal, coordinated with the Office of Management and Budget, will be submitted in a timely manner.

In GAO's opinion the reporting criteria should be similar to those that are already being used by state licensing boards for private sector physicians, which include both clinical and nonclinical areas, such as felony convictions. GAO believes that Public Law 99-166 currently restricts VA's authority to report physicians for conduct not directly related to clinical competence. Thus, GAO continues to recommend that the legislation be amended in a manner similar to that discussed on p. 47.

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Abbreviations

DOD	Department of Defense
FBI	Federal Bureau of Investigation
HHS	Department of Health and Human Services
VA	Department of Veterans Affairs

Introduction

The Veterans' Administration Health-Care Amendments of 1985 (Public Law 99-166) required, among other things, that the Department of Veterans Affairs (VA), formerly the Veterans Administration, (1) report to the Senate and House Veterans' Affairs Committees on the actions it planned to take to improve its credentialing process and inform state licensing boards and others of physicians found to be clinically incompetent and (2) issue guidance on the administrative procedures to be followed when reducing or revoking physicians' privileges (i.e., provide physicians due process when taking action against their privileges). In March 1986, VA advised the Committees that it would be issuing new guidance relating to the verification of its physicians' credentials—both applicants and present employees—and was developing comprehensive guidance on both the credentialing and privileging of its physicians. On November 18, 1986, the Ranking Minority Member, Senate Committee on Veterans' Affairs, asked us to evaluate (1) VA's new guidance and (2) VA's policies for granting and removing the privileges that its physicians must have in order to provide care to veterans.

Importance of Physician Credentialing and Privileging

Verification of physicians' credentials (credentialing) and thorough examination of their ability to perform specified procedures (privileging) is receiving increasing emphasis in health care quality assurance programs. Credentialing involves the systematic and complete review of the licenses, education, and training of all physicians seeking appointment in a medical facility. It is similar to background checks of prospective nonphysician employees. Privileging is the process of evaluating physicians' clinical experience, competence, ability, judgment, and health status when granting them permission to treat certain illnesses (e.g., pneumonia or diabetes) and perform certain medical procedures (e.g., cataract extraction or appendectomy). Credentialing and privileging procedures are designed to assure that physicians are capable of performing their assigned duties. Weaknesses in these procedures could result in patients receiving poor care from unqualified physicians.

Several of the major medical health care organizations have stressed the importance of credentialing and privileging. For example, according to the Joint Commission on Accreditation of Healthcare Organizations, which establishes accreditation standards for both federal and nonfederal hospitals, in order to promote high-quality patient care, all individuals who provide patient care independently in a hospital must have clinical privileges. Since January 1989, the Joint Commission has required hospitals to verify applicants' licenses, training, experience, and current competence with the original source of this information.

Likewise, the American Hospital Association,[1] in a technical advisory bulletin dated September 1985, stated that the responsibility for credentialing physicians lies with the hospitals. It further said that each institution should assure that all physicians providing patient care are appropriately trained and qualified to assume responsibilities at the level being contemplated. In their opinion, this responsibility should extend to residents[2] as well as fully licensed physicians seeking medical staff privileges.

VA's Credentialing and Privileging Process

VA operates the largest health care delivery system in the United States. Its health care facilities are concentrated in 159 medical centers, which consist of one or more hospitals and one or more outpatient clinics. The centers may also include a nursing home and a domiciliary. In fiscal year 1988, the system included 172 hospitals, 226 outpatient clinics, 105 nursing care units, and 16 domiciliaries.

About 49,660 physicians provided care to veterans during 1988. Approximately 13,000 of these were full- or part-time VA staff; 5,760 were consulting or attending physicians;[3] and about 30,900 were residents.[4] The above numbers do not include (1) physicians who provide services in VA medical centers without compensation from VA, (2) physicians who provide service in medical centers under contract to VA, and (3) non-VA physicians who provide care to veterans on a fee basis.[5]

VA's credentialing process applies to all full-time, part-time, consulting, attending, without compensation, and on-station fee-basis physicians. VA relies on its affiliated medical schools to check the credentials of their

[1]A national organization of individuals and health care organizations that carries out research and education projects, represents hospitals in national legislation, offers programs for institutional effectiveness reviews, and conducts a national program furthering education of hospital personnel.

[2]Residents are physicians (e.g., medical school graduates) who are in graduate medical training.

[3]Consulting physicians are specialists hired by a medical center to provide advice; attending physicians are hired to give or supervise services in a center.

[4]Residents generally rotate through a VA medical center and other medical school affiliated hospitals. Depending on state and medical school requirements, residents may or may not be licensed.

[5]VA does not have centralized information on the numbers of "without compensation" and contract physicians in its medical centers. This information is kept at the centers. In 1987, VA paid for about 1.8 million fee-basis visits. However, most fee-basis physicians provide care outside VA medical centers. Because VA's data base does not include information on where the physicians treat veterans (e.g., in their own office or at a VA medical center), VA does not have centralized information on the numbers of fee-basis physicians who provide care within VA medical centers (on-station fee-basis physicians).

residents. Except for residents, all physicians are required to be privileged by the medical center where they practice.

As part of each medical center's quality assurance program, the center director must assure that each physician providing care in the center has proper credentials and is granted appropriate privileges. The chief of staff, who reports to the director, is required to verify all state licenses and contact previous employers for each physician applicant. Additionally, the medical center's credentialing committee is required to review, at least annually, each physician's clinical privileges. This committee includes the chief of staff or reports through the chief of staff to the director. The review of privileges forms the basis for the renewal, reduction, or expansion of clinical privileges granted to a physician. Once physicians have privileges within a medical center, unless the privileges are formally revoked or rescinded, the physicians may continue to treat patients even if their privileges are not annually renewed.

Regional directors exercise direct line supervision over medical centers within their region. They are responsible for enforcing VA's credentialing and privileging guidance and evaluating the medical care and related services provided in individual centers. The regions' reviews of medical care and compliance with VA guidance are conducted primarily through visits to each medical center by a team of health care and administrative personnel. According to regional quality assurance officials, each medical center should be reviewed at least every 3 years. Central office officials told us that the review should include an evaluation of the medical center's credentialing and privileging processes.

The Office of Clinical Affairs in VA's central office is responsible for establishing policies, procedures, and guidance on credentialing and privileging of physicians. In addition, four offices in VA's central office have a role in this area:

- The Office of Quality Assurance coordinates the guidance given to the regional offices for medical center reviews. It is also one of the many offices that reviews reports prepared by the regions on the results of their medical center reviews.
- The Office of the Medical Inspector and the Office of General Counsel review and approve requests by VA medical centers to notify state licensing boards of terminated physicians' poor performance.
- The Office of Inspector General is responsible for determining the degree of compliance by VA medical centers with VA regulations and has reviewed aspects of VA's credentialing process.

VA Revisions to Its Credentialing and Privileging Procedures

In 1986, VA developed several credentialing procedures to correct problems identified by the Inspector General in 1985. The Inspector General had found that due to weaknesses in VA's existing guidance and the VA medical centers' incomplete implementation of the guidance that did exist, sanctions taken by state licensing boards against physicians' licenses were not being detected by the centers. VA advised the Senate Veterans' Affairs Committee in March, May, and December 1986 that new procedures were being implemented to overcome the weaknesses. VA also revised its physician application form. The new form requires applicants to disclose all their state medical licenses and asks them to provide information on the status of their Drug Enforcement Administration certificate (which allows them to prescribe certain controlled substances), and whether clinical privileges have ever been denied, restricted, or revoked. None of this information was obtained through the previous application.

VA's credentialing procedures now require that VA medical centers obtain information from the Federation of State Medical Boards on disciplinary actions taken against all applicants for VA physician positions.[6] The guidance further requires medical centers to verify all medical licenses listed on the application with the cognizant state licensing boards and to document that verification.[7] If physician applicants are found to have a sanction against any of their licenses, central office approval is required before they can be hired. This guidance applies to full-time, intermittent, part-time, consulting, attending, without compensation, and on-station fee-basis physicians; residents are excluded. Before this policy change, VA required only that one license be verified and as long as it was unrestricted, the medical center could hire the physician.

VA's only guidance regarding the granting of initial privileges or the renewal of privileges is a statement in its regulations that requires an annual review of physicians' privileges. However, in response to Public Law 99-166, VA issued guidance on the procedures to be used to assure that physicians are given due process when their privileges are reduced or revoked. The procedures include allowing the physician to review all evidence, request a hearing, and appeal to the regional director.

[6]The federation is the national organization of medical licensing and disciplinary boards, including the medical boards of all the states and 11 osteopathic medical boards. The federation maintains a computerized data base of disciplinary actions (such as license revocation, probation, and suspension) taken by state licensing boards and other authorities against physicians.

[7]States issue licenses to physicians authorizing them to practice medicine. If it is proven that a physician's performance was deficient or inappropriate, a state can impose sanctions, such as revoking or restricting a physician's license or placing him/her on probation.

In July 1987, the Department of Medicine and Surgery, now the Veterans Health Services and Research Administration, identified the credentialing and privileging of physicians as a high-risk area under the Financial Integrity Act. This decision was based on the fact that credentialing and privileging had been identified as either a high risk or potentially high risk at several medical centers. High-risk areas identify potential risks in agency operations that require corrective action or further investigation and should be acted upon during the first year they are identified.

Objectives, Scope, and Methodology

On November 18, 1986, the former Chairman of the Senate Committee on Veterans' Affairs requested that we examine VA's credentialing and privileging processes.[8] He requested that we

- evaluate the policies, procedures, and implementation of VA's credentialing program required by Public Law 99-166 and
- examine VA's policies and procedures with respect to the granting or removing of privileges to its physicians.

To review VA's credentialing and privileging processes and its internal controls over these processes, we visited VA's central office and eight medical centers throughout the United States and discussed our results with quality assurance officials at the four VA regional offices responsible for the medical centers we reviewed. We examined whether (1) medical center implementation complied with VA credentialing guidance, (2) physician privileges were reduced where appropriate, (3) regional office reviews of credentialing and privileging processes were adequate, and (4) the appropriate licensing entities were notified of physicians terminated by VA for clinical incompetence.

We considered the following factors in selecting the eight medical centers: (1) geographic dispersion, (2) number of physicians, (3) medical school affiliation, if any, and (4) number of beds. These factors allowed us to select large affiliated medical centers as well as small nonaffiliated centers. (See app. I.) At each medical center, we examined the facility's policies and guidance relating to credentialing and privileging. We compared the credential verification process for up to 30 of the most recently hired physicians at each medical center to VA's current required

[8]In May 1988, we issued a report on the methodology used by VA's Inspector General to identify physicians with licensing sanctions, Veterans Administration: Identifying Physicians With License Sanctions—An Incomplete Process (GAO/HRD-88-47, May 13, 1988).

credentialing procedures.[9] We also randomly selected another 30 physicians to determine how each center renewed physician privileges. To assess VA's credentialing and privileging processes, we used current VA guidance, Joint Commission medical staff standards, and the internal control standards established for the federal government by the Comptroller General. The results of our work at the eight centers cannot be projected to all VA medical centers. However, in our opinion, the findings from these centers and work elsewhere provide an accurate reflection of the adequacy of VA's credentialing and privileging processes.

To verify information on physician applications and determine whether any VA physicians had arrest and conviction records, the Federal Bureau of Investigation (FBI) matched VA physician names with its Identification Division's criminal history records.[10]

We also visited the Joint Commission, the American Hospital Association, the American Medical Association,[11] and the St. Paul Fire and Marine Insurance Company[12] to see how VA's credentialing process compared to those used in the private sector. Finally, we visited two hospital corporations to discuss their hospitals' physician credentialing and privileging policies and practices.

We reviewed documentation relating to each medical center's privileging process and ascertained if potential adverse outcomes (such as malpractice claims and investigations) were incorporated in privileging decisions. Additionally, we discussed the privileging process with medical center directors, chiefs of staff, quality assurance coordinators, chiefs of personnel, and chiefs of various services.

[9]Although we intended to choose 30 cases at each medical center, one center had hired only 15 physicians since the current guidance became effective, and at five other centers from 3 to 5 physicians in our sample were dropped because they were transferred from another VA medical center. The credentialing guidance does not apply to physician transfers. Therefore, our sample included 207 cases for which compliance with the current guidance could be tested.

[10]A June 30, 1985, physician data base developed by VA's Inspector General was used. A total of about 29,000 full-time physicians, part-time physicians, and residents were matched against FBI arrest and conviction records. We considered it a match when the FBI records and VA's data base contained the same name, date of birth, and social security number.

[11]A national organization of physicians that disseminates scientific information to members and the public; cooperates in setting standards for medical schools, hospitals, residency programs, and continuing medical education courses; and provides information to members on national and state medical and health legislation.

[12]A firm that underwrites malpractice insurance for 55,000 physicians and 1,500 hospitals

At VA's central office, we discussed our results with the Chief Medical Director and interviewed the Directors of Clinical Affairs, Academic Affairs, and Quality Assurance. We also interviewed regional office officials concerning their role in the credentialing and privileging processes. Finally, we reviewed instances in which VA reported a physician to a licensing entity. We conducted our evaluation between May 1987 and December 1988 in accordance with generally accepted government auditing standards.

VA's Credentialing Process Needs Management Attention

VA's guidance on credentialing is designed to assure that only fully qualified and suitable physicians are hired and that physicians with sanctions against their licenses can be hired only with central office approval. But seven of the eight medical centers we reviewed between May 1987 and December 1988 had not effectively implemented VA's credentialing procedures. The procedures most often not implemented involved (1) verifying physician applicants' medical licenses with state licensing boards and documenting those actions and (2) obtaining references from applicants' most recent employer. As a result, the medical centers that have not performed these functions do not have reasonable assurance that all physicians treating VA patients are competent to do so. The procedures are not being complied with because medical center personnel are misinterpreting them and regional offices are not effectively monitoring the medical center efforts.

Officials of several private sector organizations that provide guidance about or assistance in credentialing and privileging issues informed us that VA's credentialing guidance is adequate.[1] But, in their opinion, the procedures could be improved by including requirements to assure that (1) residents' backgrounds are checked to assure their suitability to treat patients, (2) applicants indicate whether they have had drug or alcohol dependency problems, and (3) all physicians' credentials are checked for accuracy with the issuing organization. With respect to the latter, Joint Commission accreditation requirements instituted in January 1989 now call for the verification of all credentials with the issuing organization, when feasible.[2]

[1]In a report dated October 1988, Physicians Applying for Federal Service: Requirements and Credentials Verification, the Department of Health and Human Services' Office of Inspector General stated that many of the best practices identified in his report reflect recently revised physician qualification and verification procedures of the military, the Public Health Service, and VA.

[2]According to a Joint Commission official, the Commission would agree that it was not feasible to verify credentials when the issuing organization was a foreign school.

Medical Center Compliance With Credentialing Procedures Is Inconsistent

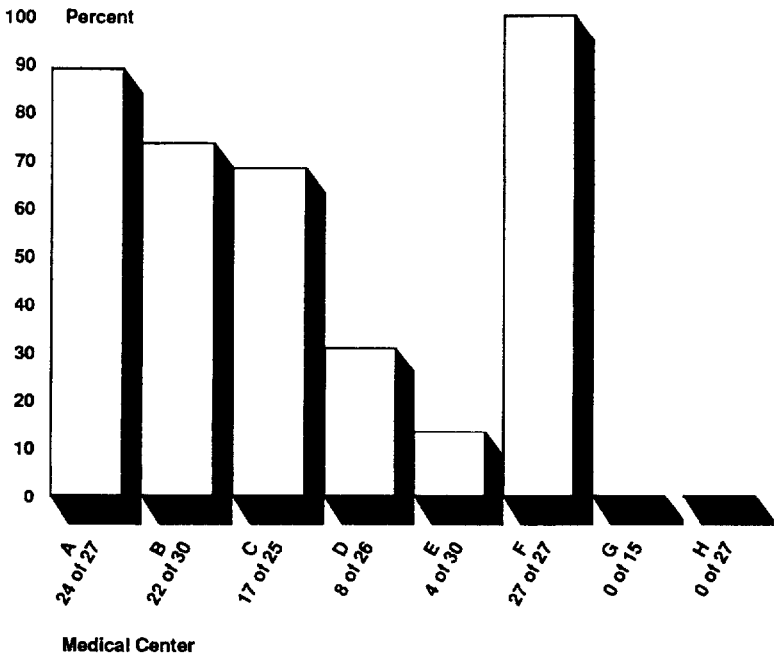
During our reviews at eight medical centers in 1987 and 1988, we found that seven were not adequately following VA's revised credentialing guidance, which has been in effect since 1986. Although all eight centers were using the new application form, compliance with the requirements to verify and document all applicants' state license(s), obtain preemployment references, and match applicant names and license data with the federation data base varied significantly.

Verification of Physicians' Licenses Either Not Performed or Not Adequately Documented

We reviewed 207 case files of physicians who had been hired since VA implemented its new credentialing procedures; in 71 cases, applicants' licenses were apparently not verified to their source. Medical center personnel stated that all the licenses of 136 physicians had been verified to their source, but only 102 of these files contained documentation indicating that licensing information had been obtained from all the cognizant state licensing boards. Failure to verify all of an applicant's licenses and document this verification violates applicable guidance and provides no assurance that all physicians treating VA patients are properly licensed and certified as capable of providing medical treatment. Further, by not documenting verification actions, a basic tenet of internal control is violated. Significant internal control events are to be clearly documented, and the documentation is to be readily available for examination.

Only one of the eight medical centers documented that all licenses had been verified in all the cases in our sample. The other medical centers had various levels of compliance, as shown in figure 2.1.

Figure 2.1: Physician License Verification and Documentation Varied Among Medical Centers



At the five medical centers with the lowest compliance, the chiefs of staff were making their own rules regarding verification and documentation:

- Medical center C normally verified only one license of each applicant. When an applicant had only one license, the verification was adequately documented. But, when a physician had more than one license, only one was verified and documented. This would identify recent sanctions against only one of the physician's licenses, not all of them. After we pointed out the requirement that all should be verified, the chief of staff said he would start doing so with state licensing boards.
- Medical center D compared applicant data only with data on file at the federation. The chief of staff believed that this satisfied the verification requirement and felt comfortable with the medical center's procedures. But state licensing boards have the most current data on physicians' licenses because they originate and report their actions to the federation.
- Medical center E had just begun to verify the licenses of applicants at the time of our visit. The chief of staff was not sure why this requirement had not been implemented previously.

- Medical center G accepted a copy of the applicant's license and the current renewal as bona fide evidence that the license was unrestricted. The license was not verified to its source.
- At medical center H, the chief of staff said he verified all licenses through calls to the state boards but did not document the calls. As a result, there is no way to tell whether all state licenses were verified for all physician applicants and VA cannot monitor whether the medical center is in compliance with its guidance.

The other two medical centers had documentation to show that the state licenses for 46 of the 57 physicians in our sample had been verified to their source. When informed that some licenses had not been verified, both chiefs of staff involved stated that medical center procedures require verification and that the verification should be documented. They did not explain why some cases had apparently been missed.

Preemployment Reference Checks Not Documented Consistently

VA's guidance requires that preemployment references be obtained for each applicant. This provides VA some assurance that the applying physician has accurately depicted his qualifications. Eight-one of the 207 cases we reviewed did not have documentation showing that references were checked. Compliance with this requirement varied by medical center:

- Three documented that they had obtained preemployment references for all of the 84 cases we reviewed.
- One center had not documented reference checks for any of the 30 cases we selected.
- Four medical centers had no evidence that they had obtained references for 51 of the 93 cases we reviewed.

In 64 of the 81 cases without documentation for preemployment reference checks, the chiefs of staff said they obtained oral comments from previous employers and colleagues. Two of these chiefs of staff believed that the responses of employers were more candid when they requested oral rather than written responses.[3] In the other 17 cases, no preemployment reference checks were apparently made; the chiefs of staff at the two medical centers involved did not explain why.

[3]In his letter dated July 11, 1989, commenting on a draft of this report (see app. II), the Secretary of Veterans Affairs stated that written responses are preferred to oral responses and, whenever possible, oral responses should be followed up by written responses. He further stated that when telephone checks are made, a report of contact should be prepared citing a summary of the information obtained and the reason a telephone check was made in lieu of a written communication.

Physician Applicants' Licensing Data Are Generally Matched With Federation's Data

Seven of the eight medical centers matched licensing data obtained from physician applicants with information contained in the federation data base for over 90 percent of the applicants we reviewed. The other medical center had a compliance rate of 40 percent—12 of 30 cases we reviewed, 9 of which were consulting and attending physicians. This center's chief of staff did not believe that the matching process was important; he said that no consulting and attending physicians were matched with the federation data because the regional office indicated that such physicians did not need to be matched. The regional office official responsible for this center stated that to his knowledge, no one from the region had informed the medical center that consulting and attending physicians were excluded from this requirement.

At one of the seven medical centers with high compliance, we were told that it did not match licensing data with the federation for any of its consulting and attending physicians. This involved 213 physicians, all of whose credentials would have been matched had the medical center complied with VA guidance.

Regional Offices Provide Limited Oversight

Regional offices are responsible for enforcing VA's credentialing guidance. Therefore, we examined quality assurance survey reports prepared by the four regions responsible for the eight medical centers we reviewed. Five of the centers (in three of the regions) had been surveyed since 1986, when the new guidance was implemented. Examination of the reports on these medical centers and discussions with regional quality assurance officials showed that regional survey teams did not always examine compliance with credentialing procedures during their surveys. Further, when compliance was examined, the surveyors did not consistently use the most current VA credentialing guidance as criteria. As a result, the regional office surveys of medical centers showed none of the compliance problems with VA's credentialing guidance that we found.

According to officials at two of the regional offices, they lack adequate staff to monitor compliance with all VA quality assurance policies. Thus, these regions generally survey a medical center's credentialing process only if the Inspector General, the Joint Commission, or organizations like GAO identified it as a problem area. When they visit a medical center, they focus on previously identified problems to determine if they have been corrected. Further, according to these officials, when a survey of credentialing is conducted, Joint Commission standards and/or guidelines developed by the central office for regional office quality

assurance surveys are used as criteria. The problem with this process is that these central office survey guidelines have not been updated since 1986 and do not include VA's current credentialing procedures.

Officials of the other two regions said that credentialing is surveyed during their 3-year medical center surveys. However, the specific procedures to be followed are left up to the survey team. One of the regional offices assessed the medical center's credentialing process using only Joint Commission standards, whereas the other region used both Joint Commission standards and VA's current credentialing guidance.

Of the five regional office reports we reviewed, four made no mention of credentialing. We found that two of these medical centers had not complied with some of VA's credentialing requirements. A fifth report indicated that all aspects of the credentialing process appeared to be "in good order." At this medical center, we found that in the 30 cases we selected during our review, the medical center had not (1) verified all the physicians' licenses with the cognizant state boards prior to appointment (8 cases), (2) documented preemployment references (30 cases), and (3) matched all the applicants' names with the federation (18 cases).

Central Office Delays Promised Changes

In 1986, VA told the Senate Veterans' Affairs Committee that, once every 2 years beginning in 1987, VA would match all currently employed physicians with data from the federation[4] to identify any sanctions taken against physicians after they were hired. As of February 1989, VA had not performed this matching. Such matching is important because, in 1986, the Inspector General identified 21 physicians employed by VA who had sanctions taken against their licenses after they were hired. In fact, seven of these physicians had sanctions against all their licenses. At the time of this finding, VA was not aware of any of these situations and assured the Committees that every 2 years, it would use federation data to identify sanctions taken against licenses of VA physicians to help assure that this type of problem did not recur.

The Office of Clinical Affairs' official responsible for developing and implementing the procedures for this matching believes that the match will take place in 1989 and attributed the delay to a lack of staffing.

[4]We discussed VA's planned biennial matching methodology in a May 13, 1988, report, Veterans Administration: Identifying Physicians With License Sanctions—An Incomplete Process (GAO/HRD-88-47). We concluded that without recommended changes, the Veterans Health Services and Research Administration would exclude certain categories of physicians authorized or paid by VA to treat veterans. We also identified methods to improve the efficiency of the biennial match.

According to this official, since 1986 there has been only one individual assigned to revise VA's credentialing process, develop the biennial matching of physicians, develop credentialing and privileging policies, and respond to the day-to-day inquiries about credentialing and privileging.

Experts in Nonfederal Sector Suggest Expanded Procedures

We discussed the credentialing procedures contained in VA's guidance with representatives of the American Medical Association, the American Hospital Association, the Joint Commission, and the St. Paul Fire and Marine Insurance Company. These representatives told us that VA's guidance is adequate but improvements could be made to allow VA to make more informed decisions about applicants' qualifications. Based on their observations and experience in nonfederal hospitals, these representatives believe that VA should (1) receive some assurance that residents' backgrounds are properly checked, (2) ask the applicants if they have or have had a drug or alcohol dependency problem, and (3) verify all credentials with the issuing organization.

In their opinion, these revisions would give VA (1) some assurance that the residents in its medical centers have the proper training and backgrounds to treat veterans and (2) additional information about applicants so that it can identify physicians whose background indicates problems, such as alcohol or drug dependency, that could affect their ability to provide quality care to veterans.

Residents Excluded From Credentialing Process

VA may unknowingly be allowing residents with licensing problems or undesirable backgrounds to treat veterans. According to the Acting Chief of Academic Affairs, VA relies on affiliated medical schools to verify residents' backgrounds. But VA's affiliation agreements with these schools do not specifically require that residents' backgrounds be checked. Reviews by the Inspectors General of both VA and the Department of Health and Human Services (HHS), and our analysis, indicate that medical schools may not be adequately checking residents' backgrounds.

In the VA Inspector General's 1985 review of VA physicians' licenses, 17 of the 93 physicians identified as having current or previous licensing sanctions were residents. Additionally, the HHS Inspector General reported in June 1986 that residency programs often have inadequate

credentials screening procedures.[5] The report concluded that as a result of inadequate procedures, medical schools may be admitting people to residency programs who should not be admitted.

Further evidence of the need to check residents' backgrounds is provided by an analysis in which we matched the names of all VA physicians, including residents, with the FBI's criminal history records. Information the FBI provided indicated that 165 of 16,756 resident physicians on VA rolls as of June 1985 had been charged with 275 criminal offenses from the early 1970s to May 1987. The charges included a wide range of offenses, the most prevalent of which related to the sale and use of illicit drugs (24 percent) and motor vehicle violations involving the use of alcohol (25 percent). Other offenses ranged from burglary and sex offenses to disorderly conduct. It must be recognized, however, that a "charge" does not equate to a "conviction" and the FBI information did not consistently indicate the disposition of the case (that is, a conviction, acquittal, or dismissal).

Examples of the more serious offenses are provided in the following paragraphs:[6]

A resident was arrested 10 times on 15 charges from January 1980 through October 1986. Charges included the false report of a crime, assault with a deadly weapon, hit and run, and possession of drugs. Upon entering a VA residency program in 1984, this individual stated on his VA application form that he had not been arrested for or convicted of a crime. Also, he did not notify VA of a restriction against one of his two licenses. The medical center's chief of staff assumed that the medical school had checked the resident's background. But, according to a medical school representative, the school does not verify residents' licenses. As a result, no one knew that sanctions existed against this resident's license. The VA medical center learned of the resident's problems only after he applied to a third state for a license and the state denied his request because of actions taken against his existing license and previous problems. This resident is no longer employed by VA.

[5]Medical Licensure and Discipline: An Overview, Department of Health and Human Services, P-01-86-00064 (June 1986).

[6]VA asks resident applicants if they have ever been convicted of, or are under charges for, any felony or any offense involving firearms or explosives and if during the last 7 years, they have been convicted or charged for any other offense. VA medical centers, however, are not required to verify any of the information for residents. (See p. 11.)

Another resident was arrested 11 times on 17 charges from 1974 to 1985. The charges included petty larceny, contributing to the delinquency of a minor, assault with a deadly weapon, and violation of the Controlled Substances Act. He was a VA resident in 1985 and was employed by VA as of February 1988.

As a result of our review, the Chief Medical Director told us in May 1988 that VA was planning to require medical schools to provide some type of assurance that residents' backgrounds have been checked. According to an official in the Office of Academic Affairs, VA is working on guidance to start requiring some assurance from each affiliated medical school that residents' backgrounds are checked. However, as of March 1989, VA had not issued any guidance to its medical centers to implement these changes.

In his July 11, 1989, letter commenting on a draft of this report (see app. II), the Secretary of Veterans Affairs questioned the legitimacy of using FBI arrest records to make general judgments about the resident screening process and stated that VA would be ill directed to make any judgments based on unresolved charges from years ago. The Secretary further stated that even if an individual had been convicted, school and VA officials may have been aware of some of these convictions and made appropriate suitability determinations.

We did not include these data with the expectation that VA would make judgments based on unresolved charges from years ago. Rather, we presented the data to demonstrate the type of background of some residents working in the VA system and, thus, the need for VA to obtain additional information from its affiliated medical schools concerning its residents' backgrounds.

VA Makes No Inquiry About Drug or Alcohol Dependency Problems

VA's new application form does not require the physician applicant to provide any information about past or current drug or alcohol dependency problems. Yet most actions against a physician's license are drug or alcohol related. In a June 1986 report on medical licenses and discipline, the HHS Inspector General stated that self-abuse of drugs or alcohol is the second most common violation for which sanctions were taken against a physician's license. The most common violation was the inappropriate writing of prescriptions, which includes the unlawful distribution of controlled substances to drug addicts. Together these two types of violations accounted for at least 75 percent of all disciplinary actions

against physicians' licenses. In addition, in 1985, VA's Inspector General noted that actions taken against the licenses of 61 of the 93 VA physicians cited were due to drug- or alcohol-related problems—either prescribing violations or personal abuse.

A question on the application, as suggested by private sector organizations, asking whether the applicant has had any alcohol or drug abuse dependency problems would allow VA to make more informed hiring decisions. It would also enable the VA to dismiss, more easily, any applicants who provided false information.

VA Requires Limited Credentials Checks

Currently, VA's credentialing policies require only the verification of a physician's medical license. However, beginning in January 1989, the Joint Commission required, as a basis for hospital accreditation, the verification of all credentials with the issuing organization. This will require VA to expand its credentials verification process to include board certifications, diplomas, residencies, and Drug Enforcement Administration certificates. The additional verification should help assure that VA has accurate and complete information about its applicants on which to base its hiring decisions and should help prevent physicians without proper credentials from being hired.

Conclusions

VA responded quickly to the Inspector General's findings on physician credentialing by revising its guidance in 1986. It has not, however, given its credentialing initiatives high priority and has not followed through on its commitments to the Congress to improve its credentialing process. VA medical centers are not effectively implementing credentialing guidance; regional offices are not adequately monitoring or enforcing compliance with that guidance; and the central office has not conducted a match of currently employed VA physicians' licenses with data from the federation. Neither the VA central office nor the regional offices were aware of medical centers' noncompliance with credentialing procedures at the time of our review. In fact, at least three of the centers did not realize that they were not complying with applicable guidance.

The verification of credentials should be one of the first steps a center takes in assuring the quality of its physicians. The effectiveness of this process can ultimately affect the quality of care provided at that center. Therefore, VA must make it a priority at all levels and take appropriate action to assure that these procedures are adhered to. By not following these procedures, the medical centers could unknowingly be allowing

physicians who have restricted licenses or other problems that may affect their competence to treat veterans. In addition, with the new Joint Commission requirement that physicians' credentials be verified with their source, VA will have to update its credentialing guidance and ensure that centers implement the guidance.

We believe VA should require its affiliated medical schools to provide assurance that residents' backgrounds are verified. We realize that FBI data may not be available to the medical schools, and we are not advocating criminal background checks. We are, however, suggesting that at least a routine check of residents' education, training, and past employment be made for all who expect to serve a residency in VA. Finally, VA should take action to identify all physician applicants who have drug or alcohol dependency problems because such problems can affect the quality of care that a physician provides.

Recommendations to the Secretary of Veterans Affairs

We recommend that the Secretary require the Chief Medical Director to:

- Fulfill the commitments made to the House and Senate Veterans' Affairs Committees in 1986 to improve the credentialing process. This includes taking the steps necessary to assure the medical centers' compliance with credentialing guidance and performing a match of VA's data regarding currently employed physicians' licenses with data from the federation.
- Incorporate procedures in regional office survey requirements to assure that each medical center's compliance with VA's credentialing guidance is examined and corrective action is taken in a timely manner.
- Obtain assurances from affiliated medical schools that residents' backgrounds have been adequately checked before they are sent to VA.
- Revise VA's physician application form to require full disclosure of any drug or alcohol dependency problems.

Agency Comments

In a July 11, 1989, letter (see app. II), the Secretary concurred with or agreed in principle to each of our recommendations to improve the credentialing process. The Secretary stated that (1) a draft policy statement on credentialing has been developed and is awaiting approval; (2) credentialing and privileging policies are being revised to reflect changes in Joint Commission requirements and should be published in December 1989; (3) the required biennial VA-federation records match will be made in August 1989; and (4) a properly promulgated system of records, concurred in by the General Counsel and approved by the Secretary, will be

developed to allow collection and retention of credentialing information in conformance with the Privacy Act. In conjunction with these actions, a proposed reorganization of VA's quality assurance functions to better integrate quality assurance functions with Clinical Affairs programs and operational line management should, in VA's opinion, satisfy our recommendations and help rectify the problems we identified.

In addition to the aforementioned actions to improve physician credentialing, the Secretary stated that VA is developing new policy guidance on the verification of residents' credentials. The guidance is expected to be complete by November 1989 and will be implemented with the academic residency year beginning July 1, 1990. The resident credentialing program will include a revised residency application form that will solicit license certification from the medical schools and will require the schools to collect other background information similar to that requested on the updated VA physician application form.

While VA agrees in principle that full disclosure of any drug or alcohol dependency problem is important to an effective credentialing process, it does not believe that our recommendation to revise the physician application form to obtain such information is the only viable alternative available. VA says it is exploring a number of mechanisms to identify physicians with drug or alcohol dependency problems. Until VA provides a better alternative, we continue to believe that a revision to the physician application form is needed.

Problems Continue in VA's Privileging Process

Various independent agencies have identified problems with VA's privileging process since 1980, and VA management has consistently agreed to take corrective action. However, our review showed that many of the problems still exist. Specifically, we found instances in which (1) physicians were providing clinical care without approved or renewed privileges, (2) support for privileging decisions was not documented, and (3) physicians who were identified as not performing to the level of their written privileges had no action taken against them to formally reduce, restrict, or revoke their privileges.

These problems exist for two major reasons: (1) VA has not adopted clear and objective guidance for determining who must be privileged and what documentation is required and (2) medical center officials are concerned that any actions taken against a physician may result in litigation against VA or specific individuals.

If executed properly, privileging processes allow for a thorough examination of a physician's current qualifications and clinical abilities to treat certain illnesses and perform specified medical procedures. If the process is not effectively implemented, the potential exists for VA physicians to treat veterans for disorders in specialty areas where the physicians are not competent to provide such treatment. Further, if physicians' clinical abilities are examined during the privileging process but are not documented, a medical center will have little support to (1) indicate it was following good quality assurance procedures or (2) withstand any objection by physicians if action is taken to restrict their privileges. As a result, the medical center may be forced to allow the physicians to continue to treat patients. Finally, if VA does not formally restrict or revoke physicians' privileges when warranted, those physicians could leave VA and practice in a nonfederal hospital with no indication on their records of past performance problems.

VA's Known Privileging Problems Have Not Been Corrected

Privileging problems at VA's medical centers have been identified repeatedly since 1980, but few corrective measures have been taken. In 1980, VA's Inspector General found that 86 physicians and medical assistants had not been granted clinical privileges as required by Joint Commission guidelines. At one medical center, the Inspector General noted that the renewal of privileges for 26 of 77 physicians, dentists, and psychologists did not follow medical center policy, and at another he noted that 20 physicians had not been granted clinical privileges. The Inspector General concluded that although the deficiencies in granting clinical privileges were found at only 5 of 66 medical centers reviewed, other centers

might have similar problems; therefore, VA should assure that every physician has been properly privileged. The Inspector General recommended that the VA central office instruct medical centers to implement a system for granting, reviewing, and updating privileges. VA concurred with the recommendation and said that the privileging process would be monitored by the regional offices and the Joint Commission.

In 1985, during an audit of VA medical malpractice claims, the Inspector General again identified problems with how VA granted and renewed clinical privileges. At one of the four medical centers reviewed, 25 of the 39 physicians sampled did not have their privileges renewed.[1] In addition, 5 of 13 physicians were given additional clinical privileges, but no documentary support was available to justify these decisions. The Inspector General also stated that a nationwide review of malpractice claims identified 10 cases, settled for $3.4 million, in which VA patients were attended by staff having questionable qualifications. At one medical center, the Inspector General was told that action to deny or restrict privileges was seldom taken because such actions could reflect on physicians' professional standing, limit their ability to practice, and result in a lawsuit against VA. In cases where a physician's competence was questioned, it was considered more expedient to take actions to terminate the physician's employment than to deny or restrict clinical privileges for cause. The Inspector General concluded that without a systematic approach to monitor and document clinical performance, the renewal of privileges had become a meaningless "paper" exercise rather than an effective control to assure high-quality patient care. In response to these findings, the Chief Medical Director indicated that VA was drafting guidance on privileging.

Since 1985, the Joint Commission has surveyed all of the medical centers we reviewed. Although all eight centers were accredited, the Joint Commission cited problems at four of them for not adequately documenting their privileging decisions. VA's regional office survey teams had also examined five medical centers we reviewed. At three of those centers, the regional teams identified problems with the privileging process: at one medical center, medical service physicians had not had their privileges renewed since 1983, and at the two other centers, documentation of the reasons for privileging decisions was lacking.

[1]Because privileges do not automatically expire, these physicians could continue to treat patients without having their privileges reviewed—i.e., without a formal assessment of the adequacy of their performance.

Although the medical centers responded to the Joint Commission and regional office reports with their planned actions to correct the deficiencies, when we reviewed those centers, many of the problems still existed because their corrective actions had not been fully implemented. For example, in January 1987, one medical center informed VA's central office that it had corrected its deficiency of not incorporating quality assurance data into privileging renewals and would have service chiefs consider the results of quality assurance activities in all future privileging decisions. However, at the time of our review in 1988, none of the privileging files we reviewed had documentation supporting the privileging decisions. Further as of June 1988, there was no indication that the regional office had followed up to determine if the corrective actions had been implemented.

In another instance, a medical center agreed to create a physician profile in response to a deficiency cited in an August 1985 Joint Commission survey. This profile was to include quality assurance information and provide documentation for privileging decisions. When asked about the status of this effort, the chief of staff informed us in January 1988 that she hopes to implement this profile once needed computer support is obtained.

Limited Guidance Adversely Affects Medical Center Privileging Decisions

VA requires its medical centers to be accredited by the Joint Commission. To be accredited, all medical staff members must have current, specified privileges that allow them to provide patient care services independently within the scope of their clinical practice. The Joint Commission also requires written evidence that the granting of clinical privileges is based on physicians' demonstrated current competence, their documented experience, the results of treatment, and conclusions drawn from quality assurance activities.

VA's only privileging guidance is one sentence in its quality assurance regulations. This statement requires each VA medical center to review, at least annually, all physicians' clinical privileges and recommend reappointment, reduction, or expansion of their clinical privileges as appropriate. While this statement establishes an annual privileging requirement, it does not provide any guidance as to how the process should occur or what documentation should be obtained and reviewed to support a privileging decision.

Privileges Are Not Always Issued or Annually Renewed

As stated above, VA requires that all physicians practicing in its medical centers have privileges to perform specific operations or procedures and that these privileges be reviewed at least annually. On the basis of this examination, physicians' privileges are to be renewed, expanded, or reduced appropriately. Without an annual examination of privileges, (1) physicians may be allowed to continue to perform procedures with which they have had problems in the past and (2) VA has no assurance that its physicians' performance and competence have been evaluated.

To determine if physicians' privileges were being examined annually, we randomly selected 30 physicians' personnel files at each of the eight medical centers reviewed. At the time of our reviews, only one medical center had renewed the privileges of all 30 cases we selected. The other medical centers had not annually renewed the privileges of 62 of 209 cases we reviewed.[2] The renewals of these cases should have been made from about 1 month to 11 years before our visits. Of the delinquent renewals, 48 involved consulting or attending physicians; 9, full- or part-time physicians; 3, without compensation physicians; 1, a contract physician; and 1, an on-station fee-basis physician. In addition, at three medical centers we found many physicians outside of our sample who had never been granted privileges but were performing in a clinical capacity.

Reasons why medical centers did not annually renew privileges varied. At two medical centers with a total of 13 consulting and attending physicians who had out-of-date privileges or no privileges at all, center officials said that those physicians were not treating patients and, therefore, renewing their privileges was not important. However, if the physicians are not treating patients at the VA medical center, they should not be on that center's consulting and attending physician list. Officials at one of these centers could not explain why the privileges of a full-time and a without-compensation physician were not renewed. Another medical center did not renew the privileges of seven consulting and attending physicians and one on-station fee-basis physician; this center's chief of staff did not believe the annual requirement included such physicians, and he could not explain why two additional physicians did not have renewed privileges. A fourth medical center, which had not renewed the privileges of 14 consulting and attending physicians, had a medical center policy that required privileging renewals only every 2 years. This

[2]At one medical center, we eliminated one individual from our sample after learning that he was a Ph.D., not a physician.

policy conflicts with VA's regulations requiring an annual renewal but it does comply with the Joint Commission's 2-year requirement.

Three service chiefs at one medical center were not familiar with privileging requirements.[3] As a result, five part-time and two without-compensation physicians' privileges were not renewed. Two of the service chiefs were uncertain about the privileging requirements. Another thought that the renewal of privileges was initiated by the chief of staff; he did not realize that under that medical center's policy, it was his responsibility to recommend renewal of a physician's privileges. Another medical center had informally restricted a full-time physician's privileges and, therefore, did not renew his privileges (see p. 32). Finally, the official responsible for coordinating the renewal of privileges at one medical center said that 14 consulting and attending physicians' privileges were not renewed because they infrequently visit the medical center and do not provide constant patient care. This official stated that it was an oversight that the remaining part-time physician's privileges were not annually renewed.

In cases where no privileges had been approved for physicians providing care to veterans, we also encountered a wide range of rationales. At one medical center, the acting chief of staff and medical center director could not explain why one part-time physician had no record of privileges being granted. At another center, the chief of staff indicated that none of the 264 consulting and attending physicians were privileged because they are brought in to assist with cases in very specialized areas and perform only limited procedures. But VA medical centers did not have documentation indicating which consulting and attending physicians were directly involved in treating patients and which were acting in a strictly advisory capacity. At a third medical center, 27 contract physicians had not been granted privileges. As a result of our inquiries, however, center officials began steps to privilege these contract physicians.

VA's Privileging Decisions Are Not Properly Documented

VA has no guidance on how and to what extent privileging decisions should be documented. As a result, none of the 239 files we reviewed had documentation to show whether current competence, results of treatment, or conclusions drawn from quality assurance information were used in any privileging decision or appraisal. According to service

[3]Within a medical center, service chiefs (such as chief of surgery, chief of medicine, and chief of psychiatry) generally report to the chief of staff.

chiefs and chiefs of staff, the support for privileging decisions was not documented because (1) renewal decisions are based on unrecorded observations by the service chiefs of the physician's clinical treatment and (2) there is no direction from VA central office on what should be documented.

Since 1985, VA has promised to develop new privileging guidance. In September 1985, the Chief Medical Director indicated that VA was developing guidance that would spell out more rigorous requirements for privileging. In March 1986, the Acting VA Administrator told the Congress that VA was developing a comprehensive new policy on credentialing and clinical privileging. When queried about the status of this policy in January 1989, the person responsible for drafting it stated that a lack of staff has delayed VA's efforts to issue it.

VA Is Restricting Physicians' Privileges Informally Rather Than Recording Its Actions

VA medical center directors are responsible for taking formal actions to restrict or revoke physicians' privileges when their performance is identified as unacceptable.[4] However, we noted only one instance in which VA began formal actions to revoke a physician's privileges and did not note any instances where VA actually restricted or revoked such privileges. In the case where VA began formal actions, the physician retired before the privileges were revoked.

We identified three instances at two of the eight medical centers reviewed where physicians' performance was questioned and their privileges were informally rather than formally restricted (e.g., the physicians were assigned to non-patient-care duties but no action was taken against their privileges). At a third medical center, we identified a physician whom the medical center encouraged to resign because it did not have the documentation necessary to support a formal reduction or revocation of his privileges. The reasons cited for taking informal rather than formal actions against physicians' privileges were that formal actions could limit physicians' ability to practice, affect their professional standing, and result in litigation against VA and the individuals involved in the action. These reasons are virtually the same as the rationale given to the Inspector General in 1985 when he found similar deficiencies.

[4]VA guidance requires medical center directors to provide full-time physicians with a due process hearing, but the guidance does not address the procedures to be followed in revoking or reducing the privileges of other types of physicians.

The following paragraphs provide examples of cases in which physicians' privileges were informally restricted:

Example 1: In 1986, two physicians and two technicians wrote to the chief of their service complaining that a fully privileged physician was repeatedly asking for help to perform certain procedures. They indicated that the physician appeared to be either insecure about performing the procedures or incapable of performing them without help. The chief of staff ordered a review of the incidents and indicated that the physician in question should not perform those procedures until after the review.

The ensuing investigation disclosed that the physician had relied on residents and fellow physicians for assistance in performing his duties. A physical standards board,[5] convened sometime later, concluded that the physician could continue to perform procedures only if he was assisted by other physicians. However, his privileges were not revised to reflect the need for assistance.

Example 2: In 1984, a medical center reviewed patient deaths because the mortality rate for patients undergoing a certain surgical procedure were about twice that of the national VA average during three consecutive semiannual reporting periods. The team conducting the review concluded that a particular resident was associated with the high mortality rate in two of the three reporting quarters and that this resident's techniques sometimes deviated from orthodox medical practice. Our discussions with medical center officials also indicated that a staff surgeon, with a joint appointment to an affiliated medical school, was allegedly not giving this resident adequate supervision.

Rather than taking formal action against the staff surgeon, the chief of surgery said, the VA medical center "denied work" to the physician. Further, the university medical school with whom he was affiliated told the physician to assist in developing procedures for surgery at a local children's hospital; another physician was then given responsibility for the medical center's surgical program. The chief of surgery indicated that the physician's privileges were not formally reduced or revoked because the medical center had not gathered enough factual data to win a case in a court of law.

[5]The board convened to determine if the employee was physically capable of performing his assigned duties.

According to the chief of surgery, the physician's associates also stopped referring patients to him and the physician eventually resigned and relocated. The resident in question graduated and his whereabouts are unknown.

Example 3: A medical center hired a physician in 1980 who was appointed service chief in 1981. He served as chief until December 1983, when he began experiencing acute anxiety and requested reassignment to a section not involved in patient care. Between 1984 and 1986, this physician performed duties that were not commensurate with his salary. In 1986, at the request of the medical center director, a physical standards board was convened to assess the physician's physical and mental capacity to perform his previous clinical duties. The board determined that the physician was physically and mentally fit to perform prior duties. But the chief of staff stated that he would not permit this physician to practice medicine at his medical center. He also stated, however, that the center did not formally restrict or reduce this physician's privileges because the physician would probably contest the restriction and begin litigation.

In these examples, the VA medical centers took informal action to restrict physicians' privileges because of questionable performance. When formal action is not taken, the physicians involved can move on to another hospital with no indication on their records of past problems. The reluctance to take action against poorly performing physicians is not unique to VA. In a report dated September 1986, the House Committee on Energy and Commerce noted that such groups as state licensing boards, hospitals, and medical societies that should be weeding out incompetent or unprofessional doctors often did not do so. The Committee learned that, even when such bodies acted against poor performing physicians, these physicians moved to different hospitals or states and continued their practice. Two reasons were given for this: (1) hospitals too often accept voluntary resignations of incompetent doctors in return for the hospital's silence about the reasons for the resignations, and (2) there was no comprehensive national reporting system to follow poorly performing physicians from place to place. According to the Committee's report, hospitals agreed to accept voluntary resignations in order to avoid lengthy and unpredictable litigation.

As a result of these findings, in 1986 title IV of Public Law 99-660 established comprehensive reporting requirements. For example, the law requires hospitals reporting to the Secretary of HHS, or an appropriate public or private agency the Secretary selects, disciplinary actions

against physicians (such as restrictions and revocations of privileges, censures, and reprimands) and payments in settlements of malpractice claims. For the protection of those who report, the law offers immunity from damages if they (1) report as required and (2) provide adequate notice of the proposed action and a hearing to the physician who is being reported. This legislation led to the creation of the National Practitioner Data Bank. Creation of the data bank was delayed because of a lack of funding, and is not likely to begin until 1990.

Although it does not cover VA, the law requires the Secretary of HHS to try to enter into a memorandum of understanding with VA. VA has been meeting with HHS to discuss the data bank, and the Secretary of Veterans Affairs informed us that he expects a memorandum of understanding to be signed in the summer of 1989.

Conclusions

VA's privileging problems have existed throughout the 1980s and are well documented. During this time, VA's central office and medical centers have repeatedly promised to take action to correct identified problems. However, the promised actions have not been implemented, and the privileging problems still exist. This does not mean that the medical services provided in VA are substandard or that VA physicians are incompetent. It does mean, however, that VA cannot assure either the public or the veterans that it has taken the necessary steps to assure that its physicians are competent.

We appreciate that developing and documenting a case against a physician that can support the formal revocation or restriction of a physician's privileges can be a time-consuming and laborious task. We also recognize that VA medical center officials are concerned about litigation resulting from taking actions against physicians' privileges. But, by documenting its privileging decisions as required by the Joint Commission and providing affected physicians with due process, VA could alleviate some of the litigation concerns. If physicians are found to be incompetent to perform duties for which they are privileged, corrective actions should be taken. It is not adequate to informally reduce physicians' privileges or let them quietly resign and seek employment elsewhere.

Recommendations to the Secretary of Veterans Affairs

We recommend that the Secretary require the Chief Medical Director to:

- Fulfill the commitments made to the House and Senate Veterans' Affairs Committees in 1986 to improve VA's privileging process. This includes issuing privileging guidance that would specify (1) the documentation needed to support privileging decisions and (2) the types of physicians that should be privileged.
- Require regional offices to follow up on medical centers' proposed corrective actions and assure that they have been properly implemented.
- Enter into a memorandum of understanding with HHS to utilize and support the National Practitioner Data Bank.

Agency Comments

In his July 11, 1989, letter (see app. II), the Secretary concurred with each of our recommendations and stated that VA fully recognizes the importance of having current and accurate delineation of clinical privileges for all appropriate staff. The Secretary stated that in May 1989 VA's Office of Clinical Affairs convened a credentialing and privileging work group to generate a privileging policy and procedural guidelines; publication of these guidelines is expected by December 1989. As with the credentialing effort, a properly promulgated system of records to collect and maintain privileging information will be established in conformance with the Privacy Act. The Secretary's comments indicate, however, that consolidation of existing guidance into one document will resolve GAO's concerns. This is not completely correct. We believe that the privileging guidance should be more specific to allow individuals who are implementing it to understand better what is required.

The Secretary also stated that VA recognizes the need to monitor and evaluate compliance with its credentialing and privileging requirements and believed it had a process for doing so. But, based on our findings, VA now believes more specific procedures for monitoring need to be developed. Thus, the Chief Medical Director has directed that requirements be established in the regional directors' performance standards, as well as those of each medical center's top management and personnel staff, to ensure that all credentialing and privileging guidelines are monitored.

The Secretary commented that VA has been involved with the National Practitioner Data Bank since its inception and expects to sign a memorandum of understanding with HHS this summer. Accordingly, VA's new/revised credentialing and privileging guidelines will incorporate specific guidance for accessing information on VA employment applicants from

the data bank and for reprivileging all professionals for whom information is held in the data bank.

VA Does Not Report All Problem Physicians to State Licensing Boards or the Federation

VA policy requires that state licensing boards be notified of a physician whose privileges are formally revoked for clinical incompetence or who resigns or retires after a reduction in privileges or while under investigation for clinical incompetence. Further, in response to Public Law 99-166, VA informed the Senate Veterans' Affairs Committee that those physicians would also be reported to the federation. However, because of (1) a lack of documentation to support decisions on whether to report physicians, (2) the requirement in the law that the basis for reporting physicians be related to clinical competence, and (3) the lack of a policy and guidance on providing due process for physicians who resign or retire before termination action is completed, not all problem physicians are reported to either a state licensing board or the federation. Further, even when reports are made, they are usually not timely.

From January 1986 through September 1988, medical centers requested VA central office permission to submit the names of 37 physicians to the state licensing boards and/or the federation. As of May 3, 1989, the central office approved 12 requests for submitting names to state licensing boards and had reported 6 of the 12 to the federation. VA attorneys informed us that more names were submitted to the state licensing boards than to the federation because they believe that the boards hold hearings before taking action against physicians. They informed us, however, that in their opinion the federation does not provide a physician due process before making information on the case available to potential or current employers. Thus, VA does not submit to the federation the name of any physician who has not received a due process hearing within VA.[1] For the 12 physicians who were reported to state boards, VA took an average of 9 months from the time the request was made to report the physician until his or her name was submitted to a state licensing board. Waiting for more documentation was the primary reason for this delay.

VA's central office rejected 17 medical center requests on the basis that they either lacked sufficient documentation or were based on something other than the physician's clinical incompetence. Of the other eight requests, five were pending as of May 1989, and three were closed because a medical school reported the physician to the cognizant state licensing board or the U.S. attorney took action against the physician.

[1] A due process hearing must provide the physician with certain rights, including: notice of the basis for the proposed action, access to all evidence that will be considered as part of the proceeding, and an opportunity to appeal to a VA official outside of the medical center involved.

In addition to submissions to state licensing boards and the federation, VA maintains an internal listing of physicians it does not want to rehire—without central office approval—for various reasons, including clinical incompetence, drug abuse, and unprofessional conduct. This is called a cautionary list. VA has not used this list effectively to notify its medical centers of former VA physicians with such problems. Specifically, it has not placed all the names of physicians it has reported to state licensing boards and the federation on this list, nor has it included physicians who were identified by the Inspector General as having licensing problems. If VA does not keep this list current, one of its own medical centers may unknowingly hire a physician who was identified as a problem at another of its centers.

VA Reporting to State Licensing Boards and the Federation Is Limited

When a VA medical center identifies a physician who it believes is clinically incompetent, action is supposed to be taken to reduce or revoke his or her privileges, and if the physician leaves VA, he or she should be reported to the state board and the federation. However, because of documentation problems and due process considerations, VA is not reporting as many physicians as it should. Before a physician can be reported, certain procedures must be followed. For example, in the case of a full-time physician alleged to be a deficient performer, a hearing is given at the medical center. If, after the hearing, the physician's privileges are revoked, he or she must be terminated from VA. But before the physician can be reported outside VA, the name of this individual and the circumstances involved in the case are forwarded to VA's Medical Inspector and Office of General Counsel. The Medical Inspector examines all documentation submitted by the medical center to be sure that the evidence indicates clinical incompetence. The Office of General Counsel reviews the case to be sure that the Privacy Act and the physician's right to due process were adhered to. The General Counsel also examines all documentation to assure that it is sufficient to withstand possible litigation. If, after this review, it is determined that an individual is clinically incompetent and documentation will withstand litigation, the Medical Inspector gives the medical center approval to report the physician's name to the state board and submits the name to VA's Office of Clinical Affairs for submission to the federation.

From January 1986 through September 1988, the Medical Inspector received 37 requests to notify state licensing boards about former VA physicians. As of May 1989, the Medical Inspector and Office of General Counsel had approved 12 of these requests but had rejected 6 because the documentation did not prove that the physician was clinically

incompetent. Further, for 6 of the 12 requests that were approved, the names have not been sent to the federation because VA had not determined whether a hearing was necessary to assure that due process had been provided to physicians before reporting them to the federation.

Reporting Criteria Are Restrictive

Public Law 99-166 requires that VA have a policy for reporting to state licensing boards and the federation physicians who have been found to be clinically incompetent and who left VA (1) following completion of disciplinary action relating to clinical competence, (2) voluntarily after clinical privileges were restricted or revoked, or (3) voluntarily after clinical competence concerns were raised but not resolved. VA defined clinical incompetence to mean a failure to conform to accepted standards of clinical professional practice to such an extent that it raises reasonable concern for the safety of patients. This requirement does not allow for sanctions for fraud, unprofessional conduct, or other such actions that do not necessarily affect clinical competence.

Of the 37 cases submitted, VA denied 11 requests to report a physician to the state board because, in the Medical Inspector's or Office of General Counsel's opinion, the physicians were not terminated for clinical incompetence. For example, three physicians appeared to have been terminated because of administrative or personality conflicts; one was described as having a disabling personality disorder; another was providing drugs to colleagues without a prescription; and another did not document the care he provided in patients' medical records, used incorrect diagnosis standards, and prepared a discharge summary that did not agree with the diagnosis.

In October 1988, attorneys in the Office of General Counsel informed us that they were reviewing the law to determine how broadly "clinical incompetence" could be defined. In May 1989, the decision was still pending. The attorneys indicated that until VA decides how broad to make this definition, reporting of physicians to the state boards and the federation will be determined on a case-by-case basis. For example, in May 1986, a medical center terminated a physician for drug use, and in December 1986, VA's Office of General Counsel approved a request to report him to the state board because, in its opinion, a reasonable relationship could be made between the drug use and the potential effect on clinical competence.

VA officials currently do not report physicians for unethical behavior or fraud unless they can relate these problems to their clinical competence.

But in some of the cases for which requests were denied by VA's General Counsel, a state licensing board could have taken licensing actions against the physicians.

State licensing boards can revoke, suspend, or place on probation the licenses of physicians for problems identified in table 4.1. It is interesting to note that the Department of Defense (DOD) also reports physicians for such reasons.

Table 4.1: VA Criteria for Reporting Physicians Are More Restrictive Than DOD's and State Licensing Boards' Criteria

Criteria	State	DOD	VA
Incompetence or substandard performance	x	x	x
Narcotic violations and drug abuse	x	x	
Alcoholism	x		
Unprofessional conduct or misconduct	x	x	
Felony convictions	x		
Fraud	x		
Mental/psychiatric problems	x	x	
Physical limitations		x	

Documentation Needed to Support Notification

VA guidance requires that medical centers provide supporting documentation to the central office when requesting approval to report a physician to state licensing boards.[2] This documentation can include investigation reports, copies of medical records documenting the failure to conform to generally accepted standards of clinical practice, and documentation of disciplinary action. However, medical centers are not always complying with this guidance.

According to VA's Medical Inspector, medical centers often do not provide the documentation necessary to justify reporting a physician to a state licensing board. Of the 37 requests to report physicians since January 1986, 6 were denied for lack of documentation.

An extreme example of how poor the documentation can be is a request by one medical center supported only by a local newspaper article discussing the physician's malpractice experience. The Medical Inspector denied the request. In another example, a physician resigned from a medical center after having been suspended from patient care for

[2]Medical centers only request permission for notifying state licensing boards; VA's central office notifies the federation.

cocaine use. After reviewing the evidence submitted with the notification request, the Office of General Counsel determined that the evidence was legally deficient because the physician's confession was inadequately documented. In July 1987, the Medical Inspector wrote to the medical center requesting additional documentation. As of November 1988, the center had not submitted any additional evidence, nor had the Medical Inspector followed up with the center to determine why.

The lack of documentation to support a recommendation to report a physician to a state licensing board directly ties in with the lack of supporting documentation of privileging decisions (discussed in ch. 3). According to a VA attorney, if a medical center has documentation to support its decision to revoke or restrict a physician's privileges, it will have the documentation needed to report the physician to a state board or the federation.

In 1988, VA's Office of General Counsel developed a 1-week training program for medical center, regional office, and district counsel staff that included a 2-hour session on reporting to state licensing boards and the federation. This training covered who should be reported to the state licensing boards and emphasized that reporting physicians who meet the criteria is mandatory. The training expanded on VA's guidance and identified additional evidence that can be used to support a reporting request. The evidence included signed statements from those having direct knowledge of the incidents, court convictions, records in criminal cases, and statements from all the individuals who had custody of drug or other evidence confiscated from the physician. The training was given three times in October and November 1988. According to VA officials, while attendance was not mandatory, virtually every medical center was represented.

VA Is Not Reporting Some Physicians to the Federation

VA is not reporting physicians to the federation who were charged with being clinically incompetent but retired or resigned from VA before having a hearing. This is occurring because VA wants to assure such individuals are provided due process before being reported to the federation. But VA's General Counsel has not determined whether a hearing is necessary to provide that assurance.[3] Consequently, as of May 1, 1989, VA had not reported six physicians to the federation whom it reported to the state licensing boards between March 1988 and January 1989. These

[3]As of May 1, 1989, the Office of General Counsel was finalizing a policy to address whether a hearing is required for due process.

physicians were reported to state licensing boards, according to attorneys in VA's Office of General Counsel, because these boards provide physicians with due process before taking action against a license. The attorneys told us that, in contrast, the federation accepts what is provided and does not independently investigate the facts. The Office of Clinical Affairs official responsible for reporting physicians said that until the General Counsel's decision is final, she would not report any more physicians to the federation.

VA is concerned about not violating the due process rights of physicians who leave VA before a hearing. However, due process can be satisfied by providing an opportunity for a hearing after the physician has retired or resigned. Those who choose not to have a hearing generally could still be reported to the federation.

Significant Delays in Reporting Physicians to State Boards and the Federation

In the 12 cases approved for reporting to state boards since 1986, VA took an average of 9 months from the time the Medical Inspector received a request from a medical center to report a physician until the time it approved reporting. Five additional requests to report physicians have been pending for an average of 21 months. According to the Medical Inspector, delays are caused by inadequate documentation from the medical centers.

Because of the time lapse in both the approved and the pending cases, state boards and the federation did not have current VA information about terminated physicians. If these physicians immediately applied for another position or license after they left VA, there would be no record on file at the state board or federation to indicate that a problem with the physicians' prior performance had been identified. The following case, which was originally sent to the Medical Inspector in December 1986 and was closed in January 1989, illustrates the situation.

In 1986, a VA medical center had alleged that a physician was clinically incompetent for (1) misdiagnosing a brain tumor as a sinus headache, (2) failing to order the tests necessary to rule out a subdural hematoma[1] until 3 days after admitting the patient, and (3) prescribing ampicillin (a synthetic penicillin) even though the medical record stated that the patient was allergic to penicillin. The physician resigned after being notified of his unsatisfactory performance, but before a formal investigation could be completed.

[1]A blood tumor in the brain.

In April 1987, while VA was considering whether to report him, the licensing board in a state where the physician had applied for a license asked for a written statement concerning such things as the physician's character and physical, mental, and professional competence. In its response to the state board, the VA medical center stated that, at the time the physician resigned, management was concerned about the physician's "clinical competence and patient administration." In July 1987, the Medical Inspector received a request for information from a hospital where the physician had applied for a staff position. In January 1988, the state licensing board again requested information concerning the physician. In January 1989, the medical center was given permission to notify the state licensing board about the physician. VA still had not responded to the hospital's request however.

VA's Cautionary List Is Incomplete

VA maintains a cautionary list that identifies physicians who are charged with unsatisfactory performance, alcohol or drug abuse, unethical or unprofessional conduct, and mental or emotional instability. These criteria are similar to those used by DOD to report physicians and the state boards to take actions against a physician. But VA is not using this tool effectively.

In its 1985 review, VA's Inspector General identified 38 physicians with current or previous sanctions against their licenses who had left VA because (1) their appointments were canceled, (2) their training was completed, (3) they resigned or retired, or (4) they were terminated by VA. Our review of VA documents indicated that using VA's criteria, 30 of these physicians should have been considered for inclusion on the cautionary list. However, none of these physicians were included, and nothing in VA's records indicates that such action was considered. For example:

- A medical center suspended a physician's privileges for poor patient care documentation and patient complaints. Additionally, other instances of inadequate or incomplete medical examinations were found in the medical records after the physician resigned. This physician should have been considered for the cautionary list because of poor performance.
- A medical center terminated a full-time physician for not possessing an unrestricted license. The state licensing board based its licensing action on the physician's drug-prescribing practices, and the medical center had previously revoked his prescribing privileges. This physician should

have been considered for the cautionary list because he did not have an unrestricted license.

In 1986 VA's Medical Inspector conducted a review of VA's placement of physicians' names on a cautionary list. The Medical Inspector concluded that there was a need for such a list to supplement other information when making appointment decisions. In his opinion, the then-current cautionary list did not meet this need. Recommendations were made and ultimately accepted by the Acting Deputy Chief Medical Director in January 1987 to update and improve the list. One of the specific recommendations was to automatically include all names of individuals who are reported to state licensing boards on a cautionary list. This recommendation was not implemented, and only 5 of the 12 physicians reported to state boards since 1986 have been placed on it. Revised procedures are expected to be issued during fiscal year 1989.

In his letter dated July 11, 1989 (see app. II), however, the Secretary informed us that in order to protect the rights of individuals who could potentially be included on the cautionary list, VA had pledged to cognizant congressional committees that the list would be used carefully and judiciously. In VA's opinion, a policy of including the names of all physicians reported to state licensing boards or the federation on a cautionary list would be inconsistent with VA's commitment to use the list carefully and judiciously. The Secretary stated that the determination as to whether a person will be included on the list is based solely on whether any of a variety of errant behaviors with which an individual has been charged involves jeopardy to the health and safety of patients. According to the Secretary, that standard carries with it more demanding due process rights than the standard for reporting to state licensing boards.

We disagree with the Secretary's position on this matter. Under existing practice, a physician employed by VA would be reported to a state licensing board or the federation only for clinical incompetence. Thus, inclusion of their names on a cautionary list would not be inconsistent with VA's commitment to use the list carefully and judiciously. Further, according to VA guidance, an individual can be placed on a cautionary list for a variety of reasons, including unethical conduct or conduct unbecoming to a professional. This encompasses a much broader spectrum of offenses than those involving only the health and safety of patients.

We also disagree with the Secretary's statement that the due process standards for an individual considered for the cautionary list are more

demanding than those for an individual being considered for reporting to a state licensing board. The due process requirements are significantly less demanding for individuals considered for a cautionary list than for individuals considered for reporting to a state licensing board. Specifically, if an individual is being considered for a cautionary list, VA's Office of Personnel will send a letter to the individual at his or her last known address giving the reasons why the individual's name is suggested for placement on the list and offering the person a chance to provide a written rebuttal before a decision is made. If the person does not respond within the specified period, his or her name will be added to the list. If there is a response, further discussion will occur before a final decision is made. The individual will be notified of VA's final decision.

The requirements for reporting a physician to a state licensing board—which are far more stringent—are cited on page 39.

Conclusions

VA is not providing complete and current information on its former physicians to the state boards, the federation, or even its own medical centers. As a result, the potential exists for allegedly "problem" physicians to leave VA with no record of their actions on file at the state licensing board or the federation. These physicians could then be hired to treat patients by a private sector hospital or even another VA medical center.

To overcome this situation, the following three initiatives should be taken: (1) amend reporting criteria, (2) establish a policy on and inform medical centers of procedures to follow to assure that physicians who retire or resign before a hearing are provided due process so that they can be reported to the federation, and (3) require the collection of supporting documentation. Specifically, Public Law 99-166 should be revised to make VA's reporting criteria similar to those already established by the state boards. Such a change would be consistent with title IV of Public Law 99-660, which requires physicians to be reported when their privileges have been restricted or revoked for reasons relating to professional competence and conduct. Further, after VA's Office of General Counsel issues its opinion on what constitutes due process for physicians who have left VA before formal action is taken against them, the medical centers should be informed of the procedures to be followed to assure that due process is provided to those physicians before their names and reported to the federation.

In addition to these actions, VA's central and regional offices should help assure that the medical centers know what documentation needs to be

collected to support a case against a deficient performer. Without these data, cases for reporting will continue to be rejected, the time it takes to report a physician will continue to be unacceptably long, and problem physicians will be allowed to leave VA to continue their work for other employers.

VA should also take actions to improve its internal mechanism to warn medical centers about problem physicians. The cautionary list should be updated to include former VA physicians reported to the states or the federation; it should be used by medical centers to avoid hiring problem physicians previously identified by VA.

Recommendation to the Secretary of Veterans Affairs

We recommend that the Secretary require the Chief Medical Director to work with the Office of General Counsel to develop a policy and establish guidance on how to provide due process to physicians who resign or retire before receiving a hearing.

Recommendation to the Congress

We recommend that Public Law 99-166 be amended to expand the physician reporting criteria beyond clinical competence. Suggested wording for the amendment follows:

Section 204 (b)(3)(B) of Public Law 99-166 is amended as follows—

(1) by inserting "or professional performance" after "clinical competence" in subparagraphs (i) and (iii); and

(2) by adding the following new language at the end thereof: "For the purposes of this paragraph the following factors shall be considered in determining 'professional performance':

"(a) narcotic violations or drug abuse;

"(b) alcoholism;

"(c) unprofessional conduct;

"(d) felony conviction;

"(e) fraud;

"(f) psychologically or psychiatrically diagnosed mental disease;

"(g) physical limitations; or

"(h) any conduct deemed by the Secretary that places the safety of patients at risk."

Agency Comments

In his July 11, 1989, letter (see app. II), the Secretary concurred with our recommendation that VA develop a policy and establish guidance on how to provide due process to physicians who resign or retire before receiving a hearing. The task has been assigned to the Veterans Health Services and Research Administration in conjunction with the Office of General Counsel. But no time frames were cited in the Secretary's letter for completion of this effort.

The Secretary presented an alternative to our recommendation to the Congress that Public Law 99-166 be amended to expand the physician reporting criteria beyond clinical incompetence. VA proposes to develop immediately, new and comprehensive regulations that will clearly require medical center reporting of problem physicians and other health care professionals. The reporting criteria will be based on clinically relevant factors and would exclude nonclinically related offenses, such as a conviction for income tax problems. The Secretary stated that if, when developing these regulations, VA finds that statutory authority is necessary to accomplish this, a legislative proposal, coordinated with the Office of Management and Budget, will be submitted in a timely manner.

We disagree with limiting the scope of the proposed reporting criteria to clinically relevant factors. In our opinion, the reporting criteria should be similar to those already being used by state licensing boards for private sector physicians, which include both clinical and nonclinical areas, such as felony convictions and unprofessional conduct. Further, we believe that Public Law 99-166 currently confines VA's authority to reporting physicians only for conduct that directly relates to clinical competence. Hence, we continue to recommend that the legislation be amended in a manner similar to that discussed on page 47.

VA Medical Centers Reviewed by GAO

Medical center	Description[b]	Number of physicians[a] F/T	P/T	C&A	Res.	Total
Clarksburg, West Virginia	An acute general medical and surgical facility affiliated with West Virginia University. It has an authorized capacity of 251 hospital beds.	20	2	83	15	**120**
Dallas, Texas	A tertiary, acute general medical, surgical, and psychiatric facility in east-central Texas affiliated with the University of Texas. It has an authorized capacity of 868 hospital and 120 nursing home care beds.	78	69	186	444	**777**
Hines, Illinois	A tertiary, acute general medical, surgical, psychiatric, and nursing home care facility located west of Chicago affiliated with the University of Illinois and Loyola University. It has an authorized capacity of 1,291 hospital and 240 nursing home care beds.	116	94	217	193	**620**
Madison, Wisconsin	An acute general medical, surgical, and psychiatric facility located in south-central Wisconsin affiliated with the University of Wisconsin. It has an authorized capacity of 346 hospital beds.	28	55	138	84	**305**
San Antonio, Texas	A tertiary, general medical, surgical, and psychiatric facility located in south-central Texas affiliated with the University of Texas. It has an authorized capacity of 704 hospital and 120 nursing home care beds.	29	105	133	128	**395**
San Diego, California	A tertiary, acute general medical, surgical, psychiatric, and nursing home care facility located in southern California affiliated with the University of California at San Diego. It has an authorized capacity of 701 hospital and 60 nursing home care beds.	40	147	161	158	**506**
Sepulveda, California	A tertiary, acute general medical, surgical, psychiatric, and nursing home care facility located in southern California affiliated with the University of California at Los Angeles. It has an authorized capacity of 685 hospital and 200 nursing home care beds.	80	64	211	116	**471**
Washington, D.C.	A tertiary, acute medical, surgical, and psychiatric facility in the northwest section of D.C. affiliated with Georgetown University, George Washington University, and Howard University. It has an authorized capacity of 708 hospital and 120 nursing care beds.	120	35	219	153	**527**

Legend
F/T = Full-time
P/T = Part-time
C&A = Consulting and attending
Res. = Residents

[a]Based on our analysis of the June 30, 1985, data base provided by VA's Inspector General.

[b]Based on the December 1985 VA report, FY 1986-1990 Five Year Medical Facility Construction Needs Assessment.

Comments From the Department of Veterans Affairs

Office of the Secretary
of Veterans Affairs

Washington DC 20420

Department of
Veterans Affairs

JUL 11 1989

Mr. Lawrence H. Thompson
Assistant Comptroller General
Human Resources Division
U. S. General Accounting Office
Washington, DC 20548

Dear Mr. Thompson:

I am responding to your draft report VA HEALTH CARE: Improvements Needed in Procedures to Assure Physicians Are Qualified, (GAO, May 30, 1989).

We thank Senator Frank Murkowski for his interest in the Department of Veterans' Affairs (VA) credentialing and privileging program and welcome this GAO report that identifies major flaws in this critical area. We appreciate the opportunity to respond to your thorough and helpful review of VA's performance and agree that the findings in the report are basically correct.

The Department is already taking steps to live up to the letter and spirit of Public Law 99-166 that clearly reflects the intent of Congress that VA develop and implement a comprehensive credentialing and privileging process. These steps will correct the situation identified by GAO to assure that there will be no further breakdowns in complying with the law.

The Department of Veterans Affairs is committed to a totally effective credentialing and privileging program so our nation's veterans can be assured they are receiving the best possible quality of care from qualified physicians. The enclosure addresses all of the report recommendations.

Sincerely,

Edward J. Derwinski
Secretary

Enclosure

Enclosure

DEPARTMENT OF VETERANS AFFAIRS COMMENTS ON THE MAY 30, 1989, GAO REPORT VA HEALTH CARE: IMPROVEMENTS NEEDED IN PROCEDURES TO ASSURE PHYSICIANS ARE QUALIFIED

GAO recommends that I require the Chief Medical Director to:

-- **Fulfill the commitments made to the House and Senate Veterans' Affairs Committees in 1986 to improve the credentialing process. This includes taking the steps necessary to assure the medical centers' compliance with credentialing guidance and performing a match of VA's data regarding currently employed physicians' licenses with data from the federation.**

We concur with the recommendation. In 1986, the Veterans Health Services and Research Administration (VHS&RA) and the Office of Personnel and Labor Relations coordinated the development of credentialing procedures to correct problems the Inspector General identified in 1985. The resulting policies and guidance issued in 1986 in Circulars 10-86-23 and 10-86-84 were intended to provide clear and unambiguous instructions for verifying the credentials of physicians being considered for appointment at VA medical centers. Before we received your report the Office of Personnel and Labor Relations developed and now has in final concurrence a new draft policy statement on credentialing of title 38 employees. We are aware of the changes in credentialing requirements made by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) in 1989, and are revising our credentialing and privileging policies to reflect these and other changes. Revised VHS&RA guidelines should be drafted for initial review in July with final publication expected in December 1989.

The report states, "In 1988, VA identified the credentialing and privileging of physicians as a high risk area under the Financial Integrity Act." It should be clarified that, as part of the Internal Control Program, Central Office has never identified credentialing and privileging as a material weakness. However, it was locally identified as a high risk area by several individual medical facilities.

Licensure and credentials verification policies and procedures have been included in our annual title 38 training programs for personnel staffs, and to facilitate the verification process, we published Personnel Circular Letter 88-3 that provided field facilities with a roster of all physician state licensing boards. VHS&RA and the Office of Personnel and Labor Relations are preparing to conduct the required biennial VA-Federation of State Medical Boards records match in August 1989. They will also cooperate in any required followup action on employees whose licenses show evidence of some form of disciplinary action. Integral to this effort will be a properly promulgated system of

2.

records, concurred in by the General Counsel and approved by the Secretary, that will allow collection and retention of credentialing information in conformance with the Federal Government's Privacy Act.

GAO suggests that requesting information from the Federation of State Medical Boards was not as desirable as requesting information directly from state licensing boards, since "this would not indicate whether any sanctions have been taken recently or are in the process of being taken against an applicant." We disagree. Some state boards, e.g. Florida, refuse to release information on disciplinary matters prior to final action being taken.

-- **Incorporate procedures in regional office survey requirements to assure that each medical center's compliance with VA's credentialing guidance is examined and corrective action is taken in a timely manner.**

We concur with the recommendation. VHS&RA has developed a proposed reorganization of the Department's quality assurance functions. That proposal is now under review by the Deputy Secretary and appropriate staff offices. A primary objective of the reorganization is to better integrate quality assurance functions with Clinical Affairs programs and with operational line management. The proposal assigns quality assurance to a new Assistant Chief Medical Director (ACMD) who will report directly to the Associate Deputy Chief Medical Director (ADCMD), a status equivalent to the ACMD for Clinical Affairs and the Regional Directors. Thus, both program management and program review officials will report to the ADCMD who will be directly responsible to the Chief Medical Director (CMD) and Deputy CMD for quality assurance activities. This reorganization, along with the revised and strengthened policy guidelines discussed above, should help to rectify the compliance problems identified by your evaluators.

-- **Obtain assurances from affiliated medical schools that residents' backgrounds have been adequately checked before they are sent to VA.**

We concur with the recommendation. The target completion date for new policy guidance on verification of credentials for physician residents is November 1989. This will allow the new procedures to be effective with the academic residency year beginning July 1, 1990. The basic groundwork was laid last September when a work group examined the issue from the points of view of both VA and the affiliated medical schools. Current discussions also include the Association of American Medical Colleges. This consultation will intensify during the next several months. The credentialing program will include a revised residency

3.

application form that will solicit license certification from the medical schools, as well as other background information similar to that requested on the already updated VA physician application form.

When discussing residents, the report states, "VA will have to check all credentials with the issuing organization if it expects its medical centers to comply with the Joint Commission accreditation requirements instituted in January 1989." The Joint Commission has no requirements for either credentialing or privileging of residents.

The report also states that "two of these chiefs of staff believed that the responses of employers were more candid when they requested oral rather than written responses." It should be noted that written responses are preferred to oral responses, and whenever possible, oral responses should be followed up by written responses. In certain situations, telephone checks are in accordance with both VA and JCAHO policies as long as they include a report of contact or memorandum for the record that includes who was spoken to, the contact's position, the date of the call, a summary of the information provided and the reason the telephone check was made in lieu of a written communication.

The GAO report also states that experts in the non-Federal sector reported that VA's guidance is "adequate." We would point out that a recent study for the President's Council on Integrity and Efficiency found the VA policies on credentialing and privileging to be among the best of all the Federal agencies in the study Physicians Applying for Federal Service: Requirements and Credentials Verification, October 1988.

We question the legitimacy of using Federal Bureau of Investigation arrest records to make general judgments about the resident screening process. VA would be ill directed to make any judgments based on unresolved charges from years ago. Specifically:

- Fewer than 1% of the 16,756 residents matched had arrest records
- The match spanned nearly 20 years
- The disposition of the cases is unknown--were they convicted or merely charged

Second, even if the individual had been convicted, medical school and VA officials may have been aware of some of those convictions and made appropriate suitability determinations. VA's current physician application form only asks individuals if they have ever been convicted of a felony or any firearms or explosives offense or any other crimes during the past 7 years.

4.

-- **Revise VA's physician application form to require full disclosure of any drug or alcohol dependency problems.**

We agree in principle that full disclosure of any drug or alcohol dependency problems is important to an effective credentialing process. However, we believe that there are a variety of viable alternatives to obtaining this information. We are exploring the best possible mechanisms to identify physicians with drug or alcohol dependency problems. For example, drug or alcohol problems that affect employment suitability would typically be revealed by other questions already on the application. We ask whether the individual has been involved in malpractice proceedings, been discharged from employment during the past 5 years, resigned or retired pending disciplinary action or been questioned concerning clinical competence during the past 5 years, been convicted of a felony or firearms violation, been convicted of any crime during the past 7 years, etc.

GAO also recommends that I require the Chief Medical Director to

-- **fulfill the commitments made to the House and Senate Veterans' Affairs Committees in 1986 to improve VA's privileging process. This includes issuing privileging guidance that would specify (1) the documentation needed to support privileging decisions and (2) the types of physicians that should be privileged.**

We concur with the recommendation. We fully recognize the importance of having current and accurate delineation of clinical privileges for all appropriate staff. The local medical facilities' Professional Standards Boards have the fundamental responsibility to serve "as the mechanism to meet JCAHO requirements concerning the method of selection of applicants, reviewing delineation of clinical privileges, and evaluation of professional performance." (M-1, Part 1, Chapter 1, Section VII, Management functions, paragraph 1.77, Mandatory Committees/Boards, subparagraph d. Professional Standards Boards) The 1982 VA Regulations that established the Health Services Review Organization (HSRO) included credentialing and delineation of clinical privileges as a mandated HSRO/SIR (Systematic Internal Review) function. JCAHO has outlined the requirements for delineation of clinical privileges in its accreditation manuals. Since all VA medical facilities are JCAHO-accredited, we did not see a reason to reiterate the standards in a specifically published document. On March 31, 1986, VHS&RA issued Circular 10-86-41, Reduction or Revocation of Clinical Privileges. This issue is VA-specific and does not duplicate JCAHO standards.

Based on your findings, it appears GAO believes implementation would be improved by having such requirements published as separate

5.

VA documents. The Office of Clinical Affairs convened a credentialing and privileging working group in May 1989 to generate such policy and procedural guidelines; publication is expected by December 1989. In addition, a properly promulgated system of records, to collect and maintain credentialing and privileging information, will be established in conformance with the Federal Government's Privacy Act. The system will assist facilities in complying with the JCAHO requirement to establish individual practitioner-specific credentialing and privileging files.

-- **Require regional offices to follow up on medical centers' proposed corrective actions and assure that they have been properly implemented.**

We concur with the recommendation. VHS&RA, through its HSRO/SIR, has recognized the need and defined a process to monitor and evaluate compliance with credentialing and privileging requirements. However, it is apparent from this report that more specific procedures for monitoring need to be issued. The CMD has directed that requirements be established in the Regional Directors' performance standards, as well as those of each medical facility's top management and personnel staff, to ensure that all credentialing and privileging guidelines are monitored.

-- **Enter into a memorandum of understanding with Health and Human Services (HHS) to utilize and support the national clearing house of physicians.**

VA has participated in the development of the National Practitioner Data Bank (NPDB) since its inception. VHS&RA is represented on the NPDB executive committee. Pending resolution of several technical issues by the Offices of Clinical Affairs, Personnel, and General Counsel, we expect to sign a memorandum of understanding with the Department of Health and Human Services this summer. Accordingly, the Department's credentialing and privileging guidelines will incorporate specific guidance for accessing information on VA employment applicants from NPDB and for the reprivileging of all professionals for whom information is held in the NPDB.

The report erroneously refers to the NPDB, created by Public Law 99-660 as a "clearinghouse." Both the HHS staff and the contract vendor who will operate the NPDB have indicated to us that it is not a clearinghouse. Nor is it a repository of physicians' credentials. Rather, it is a source of information regarding the payment of malpractice claims, clinical privilege reductions in excess of 30 days, and state licensing board actions. Further, at a recent meeting of the NPDB executive committee, HHS representatives indicated the data bank would not likely be

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initiated until 1990, rather than July 1989 as indicated in the report.

Furthermore, the report states that entering into this memorandum of understanding "could alleviate some of the litigation concerns." It should be noted that the immunity provisions of PL 99-660 do not apply to those in the public sector.

GAO also recommends that I require the Chief Medical Director to work with the Office of General Counsel to develop a policy and establish guidance on how to provide due process to physicians who resign or retire before receiving a hearing.

We concur with the recommendation. VHS&RA, in conjunction with the Office of General Counsel, will develop an appropriate policy that will establish guidance on providing due process to physicians who resign or retire before receiving a hearing.

The Privacy Act demands that information reported to State licensing boards be "reasonably" accurate. This has resulted in some physicians being reported to state boards and not being added to the cautionary list. In such cases, VA is applying the Privacy Act standard in assuring reasonable accuracy of reported information. The responsibility for seeing that such individuals receive due process lies with the state licensing board. The Federation routinely obtains information on those cases that result in formal adverse action. It then compiles the information for access in the credentialing process.

GAO also recommends that Public Law 99-166 be amended to expand the physician reporting criteria beyond clinical competence.

VA proposes to immediately develop new and comprehensive regulations that will clearly require medical center reporting of problem physicians and other health care professionals. The reporting criteria will be based on clinically relevant factors. For example, this would exclude a conviction for income tax problems. If, when developing these regulations, we find statutory authority is necessary to accomplish this VHS&RA mandate, a legislative proposal, coordinated with the Office of Management and Budget, will be submitted in a timely manner. VHS&RA will work with the General Counsel to prepare the regulations.

General Comments

Now on p. 47.

On page 75 the report contains the statement, "VA must also take actions to improve its internal mechanism to warn medical centers about problem physicians. The cautionary list should be updated to include former VA physicians reported to the states or

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the federation; it should be used by medical centers to avoid hiring problem physicians previously identified by VA."

In response to past charges that the list was subject to abuse and to protect the rights of individuals who could potentially be included on the list, VA had pledged to cognizant congressional committees that the cautionary roster would only be used carefully and judiciously. The report suggests that each physician reported to state licensing boards and or the Federation of State Medical Boards (FSMB) also be included in the cautionary list. Adopting this policy would be inconsistent with VA's commitment to use the list carefully and judiciously. The determination that a person should be listed is based solely on whether any of a variety of errant behaviors with which an individual has been charged involves jeopardy to the health and safety of VA patients. That standard carries with it more demanding due process rights than the standard for reporting to state licensing boards. In summary, cautionary list practices have been consistent with the purpose of the list. For future purposes, particularly as credentialing practices tighten and licensure information becomes more widely shared, VA will reevaluate the list's usefulness.

The following information in the GAO draft report should be corrected:

o VA policy on credentialing and privileging procedures covers intermittent physicians as well.

Now on p. 41.
Now on p. 40.

o The table on page 66 VA Criteria for Reporting Physicians Is More Restrictive than DOD's and State Licensing Boards Criteria, does not agree with the narrative on page 65. The narrative discusses the case of a VA physician reported to a state board for drug use; yet the table on the succeeding page indicates VA does not report such individuals.

Now on p. 50.

o Appendix I on pages 79 and 80 includes a column for the number of fee basis physicians at each of the eight VA facilities in the study. The numbers reported appear questionable--there were no fee basis physicians listed for the Hines VA medical center. These data should be verified. Further, the total number of fee basis physicians is not relevant to the report, since the credentialing and privileging issue covers only on-station fee basis physicians. This column should be deleted entirely or revised to include only the correct number of on-station fee basis physicians at each facility.

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